FY 05 Health Insurance Open Enrollment Issue

Retiree Benefit Focus

Department of Administration, Office of Group Insurance Boise Idaho May-June 2004

Plan Options Available for FY 05; All Retirees Must Complete An Application Form

Health Plan Changes

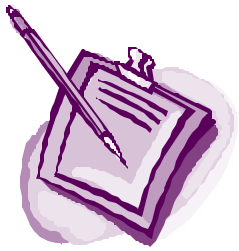
For FY 2005, as a State of Idaho retiree, you will have additional options to select from for your health insurance coverage.

These changes are the result of the Department of Administration's re-marketing of the active employee health care coverage, and comments received from the Retiree Health Insurance Survey conducted during the fall of 2003.

Important changes to the Retiree Medical coverage for FY 2005 include:

- The Prescription drug cap will be increased to $2,000 per benefit period.
- The No Cap Prescription Drug option will be offered for one additional year.
- Four plan options will be available to retirees:
  - — Traditional Plan with $2,000 Prescription Drug Cap.
  - — Traditional Plan with No Cap Prescription Drug Benefit.
  - — Preferred Provider Organization (PPO) Plan with $2,000 Prescription Drug Cap.
  - — PPO Plan with No Cap Prescription Drug Benefit.

  (See premium chart, page 2)
- An additional rate category has been added: Retiree + Child(ren). *(See page 2)*
- Both the Traditional and PPO plans have enhanced wellness benefits.
- Monthly Premiums will increase between 13-16% depending on rate categories or plan type.



What you need to do to enroll:

All retirees **must complete** a new Health Insurance Application form, which must be returned to the Office of Group Insurance **by June 15, 2004**.

An enrollment form has been included with this newsletter for your convenience. Following is a listing of things you will need to do as part of this process.

√ Select a base health plan:
- o Traditional
- o Preferred Provider Organization (PPO) Plan *(See explanation page 4)*

√ Select a Pharmacy Benefit Option:
- o $2,000 Cap per plan year
- o No Cap *(See page 3)*

√ Select an enrollment category:
- o Retiree
- o Retiree + Spouse
- o Retiree + Child (ren)
- o Family *(See page 2)*

√ Information Needed to Complete the Application:
- o Retiree Social Security Number
- o Dependent Social Security Number
- o Dependent Insurance Information (if your dependents are covered by other insurance)

√ **Complete application and return to Office of Group Insurance no later than June 15, 2004.**

If you have any questions, please call the Office of Group Insurance at: **1-800 531-0597** or **(208) 332-1860**; email: **ogi@adm.state.id.us** or contact **Blue Cross of Idaho** at **1-866 804-2253** or **(208) 331-8897**; website: **www.bcidaho.com**

Fiscal Year 2005 Monthly Premium Rates:

Fiscal year 2005 monthly premium rates for Retiree-paid Medical coverage under **Traditional** or **Preferred Provider Organization Plan (PPO)** — are as follows:
(***** New rate category: Retiree + Child (ren)

PPO Plan $2,000 Prescription Drug Cap	Retiree	Retiree + Spouse	* Retiree + Child (ren)	Family
No Medicare	$378	$670	$486	$778
One on Medicare	$183	$562	$291	$670
Two on Medicare	N/A	$354	N/A	$461
Traditional $2,000 Prescription Drug Cap	**Retiree**	**Retiree + Spouse**	*** Retiree + Child (ren)**	**Family**
No Medicare	$386	$686	$502	$802
One on Medicare	$183	$570	$299	$686
Two on Medicare	N/A	$354	N/A	$469
PPO Plan No Cap Prescription Drug Benefit	**Retiree**	**Retiree + Spouse**	*** Retiree + Child (ren)**	**Family**
No Medicare	$454	$820	$638	$1,004
One on Medicare	$259	$712	$443	$896
Two on Medicare	N/A	$505	N/A	$687
Traditional No Cap Prescription Drug Benefit	**Retiree**	**Retiree + Spouse**	*** Retiree + Child (ren)**	**Family**
No Medicare	$462	$836	$654	$1,028
One on Medicare	$259	$720	$451	$912
Two on Medicare	N/A	$505	N/A	$695

Watch for Important Membership Information From Blue Cross of Idaho

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

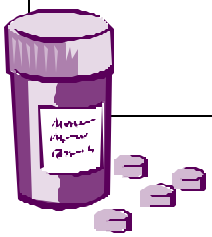
You are eligible for coverage under your new health plan effective July 1, 2004. You will be receiving a welcome letter from Blue Cross of Idaho that contains important information.

In order to assure that you will be able to access benefits on July 1, 2004 please show your welcome letter which includes your membership number to your provider or pharmacy. Also, you will need to use the following prefixes with the number, depending on which plan type you elected, traditional or PPO.

If you enrolled in the (PPO) policy, add the prefix **IDP.** If you enrolled in the Traditional policy, add the prefix **IDA.**

You should receive your Member ID card by the third week in July.

Benefit Provision	State Retiree Health Insurance Plans		
	Traditional	**PPO** ***In-Network***	**PPO** ***Out-of-Network***
Deductible	**$350 Individual $1,050 Family**	**$250 Individual $750 Family**	**$500 Individual $1,500 Family**
Office Visit	**Applied to Deductible**	**$20 Co-pay (additional services subject to Deductible and Co-insurance)**	**Applied to Deductible**
Co-insurance	**80% / 20% of allowable charges**	**85% / 15% of allowable charges**	**70% / 30% of allowable charges**
Out of Pocket Maximum	**$4,300 / Individual $8,600 / Family Includes Deductible**	**$3,250 / Individual $6,750 / Family Includes Deductible**	**$6,500 / Individual $13,500 / Family Includes Deductible**
In-Patient Hospital	**Subject to Deductible and Co-insurance**	**Subject to Deductible and Co-insurance**	**Subject to Deductible and Co-insurance**
Wellness ***This is an Enhanced Benefit***	**$250 per person, per plan year benefit for listed procedures, not subject to deductible. After $250, expenses subject to deductible and Co-insurance.**	**$20 Office Co-pay, then 100% for listed procedures. No limits per plan year. Unlisted procedures are subject to deductible and Co-insurance.**	**Not Covered, except for screening mammography services at 70% of allowable charges subject to deductible.**
Pharmacy <u>Capped</u> $2,000 Benefit per plan year	**$12 Co-payment Generic $18 Co-payment Brand with no Generic Equivalent $40 Co-payment Brand with Generic Equivalent**	**$12 Co-payment Generic $18 Co-payment Brand with no Generic Equivalent $40 Co-payment Brand with Generic Equivalent**	**$25 Co-payment, Plus 20% of the balance**
Pharmacy <u>No Cap</u> No cap per plan year	**$12 Co-payment Generic $18 Co-payment Brand with no Generic Equivalent $40 Co-payment Brand with Generic Equivalent**	**$12 Co-payment Generic $18 Co-payment Brand with no Generic Equivalent $40 Co-payment Brand with Generic Equivalent**	



What Is a PPO Plan, and How Does It Work?

A **Preferred Provider Organization** (PPO) is a network of health care providers (Physicians, Hospitals, etc.) who have agreed to accept payment levels for specific services.

The PPO Plan also offers a $20 co-payment for physician office exams with contracting physicians. Office visits to a non-contracting physician are paid by the retiree and are credited against the deductible. For a listing of PPO providers, visit **www.bcidaho.com/pdirectory/index_new.asp?id=** or contact Blue Cross of Idaho at: **331-8897** or **1-866 804-2253.**

A PPO is **not** a Health Maintenance Organization (HMO) where you must select a Primary Care Physician who then manages your access to other health care providers.

Referrals are not required in a PPO plan. You may seek health care from any health care provider. However, it is to your benefit to seek care from providers contracting with the PPO so you will have the lowest possible out-of-pocket expense.

In a PPO, you are free to select any physician and hospital you want. If your selected physician or hospital is in the PPO network, you will have a lower deductible, a higher reimbursement of expenses, and a lower annual out-of-pocket maximum.

If enrolled in a PPO and you select a health care provider who is not in the PPO network, you will experience a higher deductible amount, lower reimbursement levels for expenses, and a higher annual out of pocket maximum limit. Because non-contracting health care providers are not required to accept PPO payment levels, your physician or hospital could bill you for the extra charges.

The PPO network is slightly smaller than the Traditional network, and the payments to the health care providers are also less than under the Traditional plan. *(See PPO Qs&As, page 5-6)*

Plans Include Enhanced Wellness Benefits

Wellness and preventative efforts by State employees, retirees and their dependents are positive ways to ultimately impact claims costs.

The ***State Employee and Retiree Health Insurance Surveys*** conducted last fall identified wellness benefits as an important option.

Both of the new health plans include significantly **improved wellness benefits.** Your wellness benefit will no longer be limited to the 24 or 36-month time-frames and, in most cases, the dollar limit has increased.

Under the **Traditional Plan** specific wellness benefits will be allowed up to a $250 annual per person limit with no deductible. Wellness benefits exceeding the $250 limit will be allowed under deductible and co-insurance.

Under the **PPO Plan**, when using an in-network physician, and after a $20 co-payment, specific benefits will be covered in full with no limits per plan year.

All other benefits will be covered under the deductible and co-insurance.

How Will the Medicare Pharmaceutical Discount Card Program Affect the State of Idaho Retiree Health Plan?

Recent Medicare legislation authorized the issuance of drug discount cards to Medicare subscribers. The cards provide discounts on specific drugs for seniors until the new Medicare prescription drug program begins in 2006.

Many programs have come into existence to provide drug discount cards to Medicare subscribers.

Our research indicates that there is little benefit in acquiring a discount card if you are a participant in the State Retiree Health Plan.

Under your Retiree plan you pay a co-payment for your prescription and the insurance plan pays the balance of the cost.

All drugs that are covered are discounted from

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Frequently Asked PPO Questions

State of Idaho Health Insurance 2005 Open Enrollment

1. If I select the PPO option and I incur out-of-network expenses, what are the consequences to me?

If you or your dependent see an out-of-network provider and you have selected the PPO option, the charges could be denied or be reimbursed at lower out-of-network rates (a separate $500 deductible, 70%/30% co-insurance and a separate $6,500 out of pocket maximum). The deductible and out of pocket maximum you must meet when using out-of-network providers is separate from, and in addition to, the deductible and out of pocket maximum amounts for using in-network providers. In addition, the provider could "balance bill" you for any services not reimbursed by the PPO.

2. If my PPO physician refers me to specialist who is not in the network, or uses a non-participating lab or non-participating attending physicians in surgery, I have no choice in these situations. How will the expenses be reimbursed?

Any out-of-network provider will be reimbursed subject to the $500 deductible and 70/30 co-insurance amounts, whether referred by an in-network physician or not. In addition, as noted in question 1, you may be subject to balance billing. We advise that you discuss this with your physician before any referrals are made.

3. If my provider is in-network when I elect to enroll in the PPO, but drops out of the network in the middle of the plan year what are my options? Can I transfer to the Traditional plan?

You will not be able to change plan elections you make during this open enrollment period until the open enrollment period next year. If your PPO physician drops out of the network, you will have to decide whether to find a new in-network physician or remain with your physician and be reimbursed at the lower out-of-network levels.

4. What is the length of the PPO contract signed by the physician or the hospital? How often do physicians leave the network? How stable is the network?

The Blue Cross provider contracts are "evergreen" which means that once signed, the contract remains in place until the physician (or Blue Cross) decides to terminate the contract. In the event that the provider decides to terminate the contract, there is a 90-day period during which the provider must abide by the contract. Many providers who have decided to terminate their contracts notify their patients. Blue Cross has very stable networks. Their average turnover in participating providers is about 2%. Most of the physicians that terminate contracts are either moving or retiring.

5. What if I elect to enroll in the PPO and need to see a physician while out of state?

Blue Cross is a member of the BlueCard program through the Blue Cross/Blue Shield Association. This program allows you to have access to traditional or PPO networks nationwide.

If you need to access a health care provider when out of state, you can call the BlueCard customer service at **1-800 810-2583** and they will assist you to find a participating Traditional or PPO provider in the state you are in. That number will also be on the back of your new Blue Cross Member ID card.

You can also go to the Blue Cross website **www.bcidaho.com** and search for a provider in the state where you are located.

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PPO FAQs *(cont. from page 5)*

6. If I am in an accident and am not able to choose a PPO network hospital/provider, how will charges be reimbursed?

In an emergency, most expenses will be reimbursed subject to the in-network deductible and co-insurance amounts ($250 and 85%/15%). However, non-network providers are not bound by Blue Cross' participating provider pricing agreements, which means they may balance bill you. Also, you must notify Blue Cross within 24 hours of being able to respond so that they can help direct any ongoing care to participating providers.

7. What is the PPO $20 office visit co-payment and what does it cover?

The $20 co-payment allows for a physician office visit without first meeting a deductible. The co-payment applies only to in-network physician office visits. If the physician orders or does any tests during the office visit, such as a blood draw, charges for that test and/or lab work are paid subject to the deductible and co-insurance amounts. The $20 office visit co-payment does not apply to your deductible or to your out-of-pocket maximum.

8. Will my covered dependents or I have to meet a new pre-existing conditions waiting period?

If you and/or you dependents have been covered under the state's current plan for more than twelve continuous months, you will not have a new pre-existing condition waiting period. Newly added dependents or newly hired employees, who have been covered on another qualifying health insurance plan, with no more than a 63-day lapse in coverage prior to enrolling in the state's plan, will have their months of coverage under their previous plans credited against the 12-month pre-existing condition waiting period in our plan.

9. If I go to a participating hospital, can I assume that the physicians in that hospital are participating as well?

Just because a hospital is a participating provider does not mean that any physician or other provider associated with the hospital, i.e. anesthesiologists, are also participating. **It is important that you check with these providers to ascertain whether they are participating or not.** Non-participating out-of-network providers will be reimbursed at the lower out-of-network levels.

Insurance Information Contacts

State of Idaho Office of Group Insurance:
1-800 531-0597
(Boise Area: 332-1860)
ogi@adm.state.id.us
www2.state.id.us/adm/insurance/group_index.htm

Blue Cross of Idaho Customer Service (Continuing Care) Hotline:
1-866 804-2253
(Boise Area: 331-8897)
www.bcidaho.com

This publication presents general benefit information. In the event of any conflict between the information in this publication and the Plan provisions, the Plan documents and insurance contracts will govern. Costs associated with this publication are available from the Department of Administration, in accordance to Section 60-202, Idaho Code.

Medicare Discount Card

(continued from page 4)

retail prices. Acquiring prescriptions on the State Retiree Plan should cost less to the retiree since he or she is only responsible for the co-payment.

Under the Medicare Discount Card, the member must pay the discounted price of the drug which, in most cases, will be more than the co-payment in the State Retiree Plan.

If the State Retiree selects the $2,000 annual cap option, and exhausts that benefit, the member can still purchase prescriptions at the discounted price available to State Retirees. Typically these discounts will be greater than the Medicare discounts, and will apply to a wider variety of drugs.